

Re-Orienting Neo-liberal Development and Mainstreaming HIV/AIDS in sub-Saharan Africa

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The countries of sub-Saharan Africa (SSA) have been sites of turbulent development practices since the Third World debt crisis of the 1970s. As illustrated in Tanzania, attempts by International Financial Institutions (IFIs), namely the World Bank and the International Monetary Fund (IMF), to stabilize and liberalize the economy through the implementation of neo-liberal contingency based Structural Adjustment Programs (SAPs) only worsened conditions. It was in the shadow of deepening poverty and increasing debt obligations that the HIV virus began to permeate and devastate SSA. Government implementation of SAPs facilitated transmission of the disease by raising unemployment, increasing labor mobility, and restricting social services. Institutional reforms abated structural violence, defined by John Galtung as a process that causes “avoidable insults to basic human needs, and more generally *to life*,” (292) and compromised the human right to health, as set forth in Article 25 of the 1948 Universal Declaration of Human Rights. Under these conditions, AIDS deaths in SSA continued to rise throughout the 1980s. Poverty, debt, and illness formed a destructive cycle that set back development gains, worsened poverty, and impeded the ability of governments to adequately assist their people or help resolve their mounting debts.

In the early 1990s, worsening conditions and increasing discontent throughout the developing world necessitated that the World Bank and IMF revise their development approach. Acknowledging the incompatibility of goals for economic growth and expectations that countries

fulfill their crippling debt obligations, the IFIs introduced their most recent development programs, the Highly Indebted Poor Countries Initiative (HIPC) in 1996, followed by the enhanced version in 1999, and the Multilateral Debt Relief Initiative (MDRI) in 2006. Although the new programs prioritize poverty reduction and debt relief, they continue to emphasize the same genre of neo-liberal policies and contingency-based reforms that proved incapable of sustaining economic growth or responding to the HIV/AIDS epidemic.

However, in response to criticisms of the SAPs, the new initiatives place a strong emphasis on country ownership in the construction of development frameworks, entitled Poverty Reduction Strategy Papers (PRSPs). This new attention to participation by government and civil society provides an important opportunity for countries to incorporate a comprehensive definition and strategy for HIV/AIDS into their development programs. As exemplified by Zambia, countries can challenge the neo-liberal approach of the IFIs and employ the HIPC/MDRI as tools for combating HIV/AIDS by carefully including the epidemic in their PRSPs. Mainstreaming HIV/AIDS in PRSPs can help to ensure that towering debt burdens of the SAP era be transformed into support of social services and infrastructure that will prioritize the epidemic, combat structural violence, and protect the human right to health.

In order to explore the potential of these programs, this paper will (1) provide a historical overview of SAPs in SSA, (2) demonstrate how SAPs failed to provide the intended economic benefits and were inflexible in the face of the emerging HIV/AIDS epidemic, exacerbating high risk conditions for transmission, (3) examine HIV/AIDS as an impediment to development, and (4) evaluate the HIPC and MDRI programs as new approaches to development in sub-Saharan Africa and the potential of these programs to redefine development through the incorporation of HIV/AIDS into development instruments.

Third World Debt and the Dawn of Structural Adjustment Programs

Before the economic crisis of the 1970s, many post-colonial countries of SSA had long been dependent on foreign loans for reconstruction. The arrival of the crisis rattled the global economic order and dismantled many developing economies, dramatically shifting their positions as borrowers and rendering many insolvent (Dixon 28). The crisis was precipitated by oil-producing Arab countries' decision to raise the price of oil in 1973 and to loan profits from this spike to developing governments whose economies were suffering from the increase in oil and commodity prices (Gilpin 313). The debts accumulated by developing countries supported them temporarily but proved unsustainable in 1979 when the Federal Reserve implemented flexible exchange rates and increased international interest rates. SSA was hard-hit by this attempt to combat rapid inflation. As stated by David Simon, Wim Van Spengen, Chris Dixon, and Anders Narman in the book *Structurally Adjusted Africa*, the most notable effects of the economic crisis upon developing nations included "a global tendency towards recession and unemployment, rising debt levels, low and declining primary commodity prices, balance-of-payments deficits and increasing protectionism" (2). These conditions worsened the economic situation in developing nations and paved the way for the implementation of World Bank and IMF SAPs, medium to long-term economic restructuring devices that sought to improve economic performance and balance of trade situations (Logan 4). First taking shape in the 1980s, structural adjustment lending would define development in sub-Saharan Africa for much of the following two decades.

The SAPs administered to developing countries were rooted in the economic principles of the "Washington Consensus." This term was coined in 1990 by John Williamson in reference to his perception of "broad agreement among public officials in both the industrial economies and

international institutions on the importance of the neoliberal program for economic development and its emphasis on free markets, trade liberalization, and a greatly reduced role for the state in the economy” (Gilpin 315). These principles translated into conditionalities for lending under the SAPs. As summarized by Joe L. P. Lugalla in “The Impact of Structural Adjustment Policies on Women’s and Children’s Health in Tanzania,” some of the major conditions included:

- Control of money supply
- Devaluation of local currency
- Reduction of public borrowing and government expenditure, particularly in the social sectors and introduction of cost-sharing (user charges in education and health)
- Abolition of price controls
- Privatization of public parastatals
- Reduction or withdrawal of subsidies
- Retrenchment of workers and wage freezes
- Deregulation of laws protecting job security. (44)

Although some recipient countries complained that the measures promoted by SAPs represented a new form of capitalist imperialism, they were left with few alternatives in the face of strangling debt and a global economic crisis (Gilpin 315). Between 1980 and 1990, thirty-two out of the forty-four countries of SSA entered into a SAP (Lurie 541).

In the furrows of pervasive poverty that existed amidst the aggressive restructuring of SSA economies, HIV was silently spreading. People did not yet understand the extent to which the disease would decimate the population and impede development. Allegedly, HIV began to spread in SSA in the 1970s and continued largely undetected and uninhibited until the 1980s (Avert). By 1983, French scientists had identified HIV as the virus causing AIDS and modes of transmission were generally understood. In 1985, the first international AIDS conference took place in Atlanta, GA (Avert).

As the epidemic spread, SAPs prioritized economic growth and institutional reforms that obligated developing countries to shift public expenditures away from social services, privatize national industries, and restrict budgets. Scrutiny of World Bank and IMF programs, such as that conducted by Barnett and Blackwell in their article “Structural Adjustment and the Spread of HIV/AIDS” reveals how these programs exacerbated high-risk conditions for transmission. High-risk conditions include worsened poverty, income inequality, unemployment, increased mobility and the erosion or restriction of social services necessary to curb transmission. Contingencies of SAPs, underwritten by the neoliberal belief that “the market can do better than the state at allocating resources to different segments of society” (Logan 4), abated structural violence and promoted violations of the human right to health.

Government adherence to SAPs violated citizens’ human right to health by restricting access to the social services necessary for the “adequate health and well being of the person] and of his family” (UN *Declaration*). Newly introduced user fees restricted access and decreased the utilization of schools and clinics. Researchers recorded decreases in clinic use after the implementation of user fees in Kenya, Nigeria, Mozambique, Zaire, Ghana, and Zimbabwe with serious impacts on health: data from Nigeria reveals that after the government cut health subsidies and implemented user fees, the number of maternal deaths rose by 56% (Lurie 544). Under the guidance of SAPs, governments redirected social expenditures into the promotion of exports and industry: between 1980 and 1985 there was a 26% decline in spending on health, education and welfare in sub-Saharan Africa (Lurie 543).

Rising unemployment and poverty led to structural violence as budget cuts required retrenchment of workers and wage freezes that deepened poverty, spiked unemployment, and exacerbated transmission of HIV/AIDS. These conditions led to increased mobility as an

unprecedented number of Africans moved to cities, mines and factories in search of work. This facilitated the spread of HIV/AIDS, as migrants, primarily young men and women, isolated from traditional, cultural, and social networks will often engage in risky sexual behaviors, with obvious consequences in terms of HIV infection (Poku 195). This sort of migration has been amply documented as a major factor in the spread of HIV (Poku 536; Simon 152). Further exacerbating risk conditions, the SAP push towards exports directed migrants to urban centers where export activities are concentrated and seroprevalence is typically highest. Between 1960 and 1990, the annual urban population growth rate for sub-Saharan Africa was higher than any other region in the world at 5.2% (Lurie 542). With the convergence of these factors, there were an estimated 5,500,000 HIV cases and 650,000 AIDS cases in Africa by 1990 (Avert).

Meanwhile, despite restructuring attempts, poverty deepened and debt burdens grew. In Africa, debt service as a percentage of exports rose from 6.3% in 1970 to 19.2% in 1988, and the proportion of people living on less than US\$1 per day increased continuously from 1965-69 measurements, rising from 55.8% to 64.9% in 1995-99 (UN *Tanzania* 2). The income of the poorest 20% of the population of SSA is estimated to have declined twice as much as that of the population as a whole between 1980 and 1995 (UN *Tanzania* 2). These numbers are partnered with staggering AIDS statistics: in 1993, 9 million people in SSA were infected with HIV and there were 1.7 million AIDS cases. By the time HIPC was implemented in 1996, 19 million adults and children had been infected since the 1970 (WHO 8).

SAPs rendered countries unable to effectively deal with the epidemic and afflicted governments, cities, communities, and households watched the disease erase progress and reengage the cycle of poverty, debt, and illness. Reiterated by Dennis Altman in "Globalization, Political Economy, and HIV/AIDS", "The very policies urged by international bodies and

economic theorists to promote faster development have added to the conditions that make people vulnerable to HIV infection” (565). Despite this, the epidemic was rarely associated with its economic and development consequences and was not mainstreamed in development initiatives.

Thwarting Development: HIV/AIDS

As infection rates rose, countries working to fulfill the requirements of SAPs became further entrenched in debt. Although this cannot be solely attributed to HIV/AIDS, the epidemic certainly worked alongside other factors to disable repayment capacity by destroying labor supply and reducing productivity, income, exports and GDP growth (Nwachukwu 182). The virus is particularly efficient in destroying the development potential of countries by eliminating the most productive members of society, people in the fifteen to forty-nine year age groups. The United Nations Population Council iterates this point clearly in its report “On the Socioeconomic Impact of the HIV/AIDS Epidemic,” noting that the virus is:

...depriving families, communities, and entire nations of the young and most productive people. It is therefore uniquely devastating in terms of increasing poverty, reversing human development achievements, eroding the ability of Governments to provide and maintain essential services, reducing labor supply and productivity and putting a break on economic growth. (620)

Due to HIV/AIDS, the labor force of SSA is predicted to be 10-30 percent smaller than it would have been without the epidemic (620).

High infection rates among the remaining labor force further slowed the attainment of economic development goals. This slowing was due to the fact that infected workers are less productive and more expensive to employers. Infected workers’ needs for medical care tax employer health care programs, and decreases in worker productivity lead to decreased profits

and extra expenses. Upon the death of a worker, salary compensation and funeral grants are often paid to the families, incurring further losses (Baxter 66). Industry is particularly set back by the death of skilled laborers, who are especially vulnerable to HIV/AIDS (Hoch 166). World Bank Country Overview summarizes the impact of the death of skilled laborers: “The illness and death of experienced managers and entrepreneurs, for example, may lead to productivity declines among others far in excess of their individual productivity. Replacing highly specialized people, such as doctors and nurses, will be especially difficult given the years of training and experience involved” (World Bank 52). With this information in mind, it is significant to note that Barclays bank of Zambia has lost more than a quarter of its senior managers to AIDS (Poku 541) and more than 10% of South Africa’s civil servants and 20% of its student nurses are HIV positive (Baxter 67).

Without a productive labor supply, nations are unable to support industry, develop human capital, and foster entrepreneurship: all necessary components of sustainable development. Companies allocating significant resources to worker health may not be able to participate in activities such as research and development that are necessary for growth. Additionally, countries with an enfeebled work force and ill performing businesses are unlikely to attract foreign direct investment from multinational corporations, a necessary motivator of growth in the neoliberal economic model. The case of Tanzania provides a particularly clear portrayal of the effect of SAPs on the economy, the implications for transmission of HIV/AIDS, and the resulting development losses due to widespread infection.

Poor Development, Poor Health: The Case of Tanzania

The relationship between the government of Tanzania and the IFIs has a volatile history. Tanzania borrowed from the IFIs throughout the 1970s and sought donor aid during the

economic crisis of 1973. In 1979, tensions between the political philosophies of the government, based on socialist principles that emphasized strong social services, and the ideology of the IMF, were at odds and both parties abandoned major development programs (Holtom 552). A change of political leadership resolved this rift in the 1980s and Tanzania began its first Structural Adjustment Program in 1982. Following the economic crisis of the 1970s and amidst the debut of SAPs, HIV/AIDS spread throughout the country. The first suspected case of AIDS was diagnosed in Tanzania in 1983, although the spread of HIV probably began in the late 1970s and early 1980s (World Bank 10).

The SAP of Tanzania prioritized currency devaluation to increase exports and fight inflation as well as budget cuts to reduce spending. These cuts included abolition of food subsidies, liberalization of social services, wage reductions and lower development spending. Emphasis on exports drew populations to cities and urban populations grew from 1,073,917 in 1970 to 4,957,724 in 1990, and reached 6,340,558 in 1995. In Dar es Salaam Tanzania's largest city, administrative capital and home to most industries--the population grew from 835,957 people in 1980 to 1,668,359 people in 1995 (World Bank 16). The spread of HIV/AIDS largely mirrored migration patterns and the regions of Mwanza and Mbeya (located on the main transportation route from Dar es Salaam to Zambia) and the city of Dar es Salaam itself suffered some of the highest infection rates in the country (World Bank 16).

In 1995, the newly elected government continued to administer the macro-economic and structural adjustment policies advocated by the IMF and World Bank. This resulted in the reduction of the civil service from 355,000 to 270,000 people and divestiture of more than half of the 400 state-owned enterprises by the end of 1998. This divestiture and reorganization heavily influenced the mining sector, which by 1999 was the most rapidly growing sector of the

economy (UN 1999 17). The mining industry was (and remains) notorious for being a hotbed for HIV transmission, and this shift in the labor industry likely increased the risk of transmission (Campbell). Credit to private sector also grew from 1.5% GDP in 1988 to 10.8% in 1993, as did claims on the private sector which grew from 1.9% in 1977 to 5.79% in 1987, and again to 6.1% in 1997 (NationMaster).

Alongside economic and urban expansion, social services in Tanzania suffered. The share of health in the national budget declined from 7.23 percent in 1977-78 to 4.62 percent in 1989-1990 (Lugalla, 44). Life expectancy decreased from 53.7 in 1980 to 53.46 in 1990 and 49.86 in 1995. Population per doctor increased from 1:19053 in 1981 to 1:24, 880 in 1990 (NationMaster) and the number of hospital beds per 1000 people decreased from 1.44 in 1978 to 1.09 in 1988 and even further to .89 in 1992. Simultaneously, AIDS strained the increasingly limited health care system. As outlined in the World Bank Country Study of Tanzania in 1992:

The consequences of the epidemic for healthcare provision and costs, both public and private, will be major, requiring difficult choices among competing demands for resources, not only between AIDS and other health issues (maternal and child health care, malaria, etc.) but also within AIDS care. (xxvii)

The Tanzanian government, adhering to mandated cutbacks, was unable to provide services necessary to curb transmission or care for those already infected. Already depleted healthcare systems were further taxed by the HIV/AIDS epidemic. In addition, Tanzania's Human Development Index ranking also dropped throughout the 1990s.

Tanzania exemplifies the near impossibility of reconciling social and economic priorities under SAPs. As high debt ratios reduce social expenditures, it is difficult for countries to maintain the social services necessary for adequately addressing the HIV/AIDS epidemic (Dessy

and Vencatachellum 204). Meanwhile, the epidemic erodes the accomplishments of economic development programs and perpetuates structural violence as individuals lose income and fall deeper into poverty. As the AIDS epidemic emerged and further impeded development gains, the failure of SAPS to incorporate HIV/AIDS as an integral aspect of economic development proved calamitous. The HIV/AIDS virus derided ambitions of the IFIs by darkening prospects of development in Tanzania despite the implementation of widespread economic reform. The World Bank Country Report, published in 2009, reveals how decades after SAPs, AIDS is significantly decreasing development gains:

The presence of AIDS reduces the average real GDP growth rate in the 1985-2010 period by between 15 and 28 percent, from 4.0 percent per annum to 2.9 - 3.4 percent per annum... The impact on potential per capita GDP is more moderate, decreasing it by only 12 percent in the worst-case scenario. Under the simulation, per capita GDP is forecast to grow at an average annual rate of 0.7 percent in the hypothetical situation without AIDS, while with AIDS growth rates range between 0.3 and 0.8 percent per annum...(59)

SAPs not only failed to create real growth, they also failed to address social needs such as health and education. In the year 1997-98, the government spent four times as much on debt servicing as on primary education (UNAIDS 19). As debt burdens and structural adjustment conditions rose through the 1980s and 1990s, amounting to about 114 conditionalities per country, the degree of compliance declined (UNCTAD 17). By the late 1990s there was growing recognition that conditionality based lending through SAPs was incapable of fostering economic growth and promoting good governance (Abrahamsen 1455).

Acknowledging the need for a more comprehensive development agenda that included debt relief and poverty reduction, the IFIs introduced the Highly Indebted Poor Countries Initiative

(HIPC) and the Multilateral Debt Relief Initiative (MDRI). These initiatives emphasize country ownership and pro-poor civil society participation, using the Millennium Development Goals (MDGs) as targets and progress towards these goals as a measure of success. Examination of these initiatives reveals important opportunities for the incorporation of HIV/AIDS into national development agendas and provides cautious hope for the future re-imagining of development in a way that will disrupt the cycle of poverty, debt and illness.

Development Rephrased: HIPC & MDRI

The IMF and World Bank introduced HIPC in 1996 with the goal to “ensure deep, broad and fast debt relief and thereby contribute toward growth, poverty reduction, and debt sustainability in the poorest, most heavily indebted countries” (IDA 4). HIPC was intended to mark a shift from the “bad old days” of conditionality-based programs towards a brighter future of partnership and governance reform (Harrison 125). The initiative was enhanced in 1999 by reducing time for the application of debt relief and by placing greater emphasis on the achievement of the United Nations Millennium Development Goals. Attention to the MDGs was ensured by making relief conditional on progress towards preparation and implementation of social policies and strategies for poverty reduction (Nwachukwu 171). Additionally, the MDRI was adopted in 2006 with the goal of providing increased support to HIPCs in reaching the MDGs.

Debt relief is an essential step in the fight against HIV/AIDS. Funds from debt relief can be rerouted into AIDS specific programs which in turn will increase health, reduce poverty, revitalize the workforce, and generate the economic growth necessary for stability. As stated by the Joint United Nations Program on HIV/AIDS and the World Bank in their toolkit, “Debt relief does not only provide the possibility of having fresh resources injected in the fight against HIV.

It gives the opportunity to place HIV/AIDS at the centre of the development and aid agenda and to discuss country issues linked to policy development and budgeting” (35). A brief overview of the criteria and processes of the debt relief initiatives is a necessary starting point for understanding their significance as tools in the fight against HIV/AIDS.

HIPC Initiative

Eligibility for the HIPC initiative is determined by a country’s level of indebtedness and the provision of a Poverty Reduction Strategy Paper (PRSP). In order to be considered for debt relief through HIPC, a country must achieve a three-year period of satisfactory performance on IMF/World Bank macroeconomic adjustment reforms under the guidance of the IMF’s Poverty Reduction and Growth Facility (PRGF). After this period, the country reaches a decision point at which time it must meet a number of criteria including: (1) facing an unsustainable debt situation after the full application of the traditional debt relief mechanisms, (2) eligibility for only highly concessional assistance from the International Development Association (IDA), and from the PRGF, and (3) having established a track record of reform and developed a PRSP that involves civil society participation (World Bank).

Completion of preliminary requirements is followed by an assessment by the joint commission of the IMF and World Bank. If approved, the country receives interim relief on a provisional basis until it reaches a completion point when full debt relief can be implemented. In order for a country to reach this completion point, it must “maintain macroeconomic stability under a PRGF-supported program, carry out key structural and social reforms as agreed upon at the decision point, and implement a PRSP satisfactorily for one year” (World Bank *Steps*). As of the end of March 2007, 30 HIPCs have reached the decision point and now receive debt relief. For these 30 countries, poverty-reducing expenditures on average have risen from about 7

percent of GDP in 1999 to over 9 percent of GDP in 2005, a level more than five times of that spent on debt service.

MDRI

The MDRI serves to supplement the HIPC initiative by providing additional debt relief and maintaining focus on the MDGs. The criteria for MDRI mirror those used to determine arrival at the HIPC completion point and work to guide the savings from debt relief toward productive uses in recipient countries. Under the MDRI, countries that reach the HIPC completion point can receive 100% debt cancellation from selected creditors.

Theoretically, the combined HIPC and MDRI serve as important tools for reducing the debt burden of low-income countries and mark a step forward from the SAPs by integrating a robust definition of poverty and development and by claiming to emphasize deeper country involvement. Addressing the multidimensional nature of poverty in development programs holds the potential to combat structural violence by examining the way systems interact to restrict necessary services for the most vulnerable. The requirement that governments take part in the creation of PRSPs reflects the increased commitment to country ownership. Active participation in this process is essential because PRSPs largely determine the budgeting of resources freed up through debt relief.

Although there is no formal template for PRSPs, certain expectations exist for the documents, and the IFIs closely guide the writing process with recommendations and templates.. A PRSP sourcebook, provided by the World Bank, instructs countries in the process of preparing the document and makes recommendations on substance. According to the Joint United Nations Program on HIV/AIDS and World Bank toolkit,

An effective poverty reduction strategy would be expected to (a) be prepared by the country; (b) focus on faster and broad-based economic growth; (c) reflect a comprehensive understanding of poverty and its determinants; (d) assist in choosing public actions that have the highest poverty impact; and (e) establish outcome indicators that are set and monitored using participatory processes. (17)

By allowing governments to prioritize spending and encouraging a robust definition of poverty, PRSPs create space for a re-imagining and tailoring of development in ways that can incorporate HIV/AIDS in national programs and call attention to the epidemic as a global development priority.

Importance of PRSPs for Combating HIV/AIDS

The recommendation that governments prioritize public actions that will reduce poverty provides an obvious window for the incorporation of a comprehensive HIV/AIDS strategy. Incorporating HIV/AIDS as a priority in development instruments such as PRSPs is referred to as mainstreaming. The UNAIDS, World Bank, and UNDP review defines mainstreaming as “establishing and addressing the linkages between HIV and other development issues such as slow or negative and unequal economic growth, conflict and migration, food and livelihood security, governance and public sector performance and health issues such as malaria, tuberculosis, and maternal and child health” (11). There is widespread international support for mainstreaming HIV/AIDS in development initiatives. At the 2001 UN General Assembly Special Session on HIV/AIDS, a declaration of commitment to be achieved by 2003, was made to “integrate HIV/AIDS prevention, care, treatment and support and impact mitigation into the mainstream of development planning, including poverty eradication strategies, national budget allocations and sectoral development plans” (UNAIDS 15).

Although PRSPs have been recognized as theoretical tools for mainstreaming HIV/AIDS, they are not currently used to their full potential. In only three of nineteen PRSPs reviewed by the World Bank, UNAIDS, and the United Nations Development Project (UNDP) was HIV/AIDS addressed as a multisectorial issue that included a discussion of the linkages between the epidemic and the perpetuation of poverty (21). Even in the documents that highlighted AIDS, the transformation of stated objectives into programs has been slow (34).

In order to facilitate the mainstreaming process, agencies such as UNAIDS, World Bank, and UNDP have provided recommendations for mainstreaming HIV/AIDS programs into development PRSPs. The World Bank and UNAIDS published a toolkit for mainstreaming HIV/AIDS in 2001 and included four essential criteria:

- (1) Analysis of linkages between HIV/AIDS and poverty
- (2) Main Strategies of the national strategic HIV/AIDS plan or national action frameworks (NAFs) stated in the PRSP, justified and costed
- (3) Medium-term goals and poverty monitoring indicators derived from the national AIDS plan specified
- (4) Short-term actions for the successful implementation of the National AIDS Plan, with specific and monitorable targets that form agreements for debt relief specified. (19)

Although these serve as a good starting point for mainstreaming HIV/AIDS, a review of experiences in 2005 by UNDP, UNAIDS, and World Bank found that these guidelines did not ensure a strong and meaningful approach. According to the review, “meeting all four criteria may be necessary, but it is not sufficient to indicate effective mainstreaming” (24). In response to these findings, the commission created additional recommendations:

- (1) A more comprehensive analysis of the links between poverty and inequality, gender and AIDS using gender analysis and gender disaggregated data, targets, indicators and resources.
- (2) Factoring the implications of AIDS into the design of poverty-reduction and growth plans and economic and social reform programmes

- (3) Linking HIV/AIDS and other human rights, health, and development issues in the wider context of the Millennium Development Goals
- (4) Outlining sectoral as well as cross-cutting mainstreaming strategies together with broad resource requirements and appropriate indicators (mainstreaming)
- (5) Assessing and planning for the national human and institutional capacities requires to achieve the AIDS objectives expressed in PRSPs

As will be shown in the case of Zambia, by following these steps, countries have achieved moderate success in mainstreaming and achieved marked progress from SAPs.

Where SAPs focused their goals on economic growth, the new initiatives appear to pursue a more comprehensive definition understanding of poverty. The PRSP Sourcebook reiterates this need as follows:

To the extent possible, the description should take into account poverty's multidimensional nature by going beyond consideration of income and asset holdings of the poor to encompass the nonmonetary dimensions of poverty, particularly education and health status, vulnerability to shocks, and disempowerment. (Klugman 7)

Recognizing the non-monetary dimensions of poverty, vulnerability and disempowerment create space for these programs to attack issues of distribution and inequality that promote structural violence. By increasing support of health services PRSPs can also help protect the human right to health.

However, despite the benefits of this seemingly reformed approach, realizing the multidimensional aspects of poverty does not necessarily translate into action. The before-mentioned World Bank sourcebook recognizes that "while there may be important synergies between opportunities, security, and empowerment, in some cases there may be policy tradeoffs, at least in the short term" (Klugman 3). Statements such as these imply that there are objectives paramount to poverty reduction for which a broad definition of this goal may be sacrificed.

Allowing aspects of poverty alleviation to be included in trade offs opens a dangerous discussion of the cost benefit analysis of short-term human opportunity and health versus long-term economic growth. This reasoning is frighteningly reminiscent of the SAPs.

Regardless of these challenges, however, countries such as Zambia are effectively integrating HIV/AIDS into their development instruments. Nations that suffered under SAPs the way Tanzania did can follow the example of these countries and start on a path towards de-linking the destructive cycle they have fallen into by prioritizing HIV/AIDS as a necessary part of their debt relief and poverty reduction strategy.

The Case of Zambia

Zambia reached a decision point in 2000 and completed its current PRSP in 2002. AIDS is a highlight in this document, and the government recognizes that “The HIV/AIDS pandemic is threatening all the developmental achievements of the past decades” (Zambia 12). Since completing the PRSP, Zambia has seen a decrease in the number of AIDS deaths from 78,000 adults and children in 2001, to 56,000 in 2007 (UNAIDS 2008). The prevalence of sex workers in urban areas has decreased and overall condom use has risen alongside decreases in promiscuity. Sites providing antiretroviral therapy have more than doubled, and the number of people receiving antiretroviral therapy has risen from 20,000 in 2004 to 151,000 in 2007, marking a rise in coverage from 7% to 46% of those in need. However, the number of adults and children living with HIV is still on the rise, from 94,000 in 2001 to 1,100,000 in 2007 (UNAIDS 2008).

The Zambian PRSP meets all four criteria for essential HIV/AIDS content as set forth by the UNAIDS/World Bank toolkit and treats HIV/AIDS as a cross-sectoral “goal-level” priority.

The report directly links poverty and AIDS in Chapter 14 where it lists the epidemic as one of three priority cross-cutting issues:

The inter-relationship between HIV/AIDS and poverty is complex. The manifestations of HIV/AIDS lead to poverty, and the state of poverty directly or indirectly creates vulnerability to HIV/AIDS. HIV/AIDS leads to poverty by eliminating the productive sector of society, the 15-45 year age group. Its effect on society is primarily through the premature loss of human capital...Economic growth and prosperity hinge on a healthy human resource base and this is currently threatened by the HIV/AIDS epidemic. Investment in strategies that fight the HIV/AIDS epidemic will, therefore, have a major impact on poverty reduction. (106)

The paper also identifies the ways in which former cuts to social services impacted the epidemic and how HIV/AIDS maxes out health services, stating,

The impact of HIV/AIDS on the health care system itself has been profound. It is projected that AIDS patients will utilize 45 percent of all hospital beds by 2014, crowding out other patients. With AIDS expenditures rising, HIV/AIDS will inexorably consume more resources at the expense of other diseases. (109)

The decline in health expenditure means that the quality of sexually transmitted infections (STIs) management is compromised...STIs being co-factors for HIV means sub-standard management of infections results in increased transmission of HIV. Limited resources impede the acceleration of HIV/AIDS education in schools. (106)

The report continues to support these statements with data and refers to the country's national strategic framework. The PRSP incorporates the education sector, the Ministry of Health, the Central Board of Health, and the HIV/AIDS council in the strategy and outlines a number of

priority actions, fully costed. Some actions include: multisectoral behavior change communication campaigns, condom distribution, voluntary counseling and testing, home based care, special focus on high risk groups and children, and treatment monitoring. The specific articulation of development needs has seen positive results, and the expenditure on HIV/AIDS programs has risen significantly in recent years, from \$140,566,646 in 2005 to \$207,909,244 in 2006, a 68% increase in one year. The public contribution to the total expenditure was four per cent in 2005, and fourteen per cent in 2006 (Lifuna).

As illustrated in the *Zambian PRSP*, a detailed definition of the links between HIV/AIDS and poverty is a necessary tool for fighting the epidemic. More countries need to incorporate HIV/AIDS in this way, as noted by UN toolkit: “HIV, and links with poverty, are rarely factored into wider macroeconomic reforms. Without analysis of the consequences of macroeconomic reform, it is highly unlikely that HIV prevention, scaling up of antiretroviral therapy, care and support, and impact mitigation will be adequately addressed within PRSPs” (22). It is also important to note that though the *Zambian PRSP* explicitly names the human right to education (76), it does not include the human right to health, nor do any of the 21 PRSPs reviewed by the World Health Organization in their report, “PRSPs: Their Significance for Health.” With ample evidence to support the claim that HIV/AIDS is indeed an impediment to development and a serious factor in creating and perpetuating conditions of poverty, it is baffling that so few countries have achieved real progress towards incorporating a comprehensive approach to their development programs.

Neoliberalism and Poverty

A review of World Bank literature may help to reveal why health is not comprehensively examined in PRSPs. Even with a summary analysis of the World Bank literature on PRSPs one

can identify the perpetuation of neoliberal ideologies and priorities within the HIPC/MDRI programs. When discussing tactics for poverty reduction, the World Bank emphasizes that “Structural policies to improve the functioning of markets are thus critical. Similarly, good governance is crucial to accelerating private investment and thus economic growth” (8). The primacy of markets and privatization continues to be heralded as the best method for promoting poverty reduction.

The conceptualization of health in the World Bank PRSP Sourcebook also testifies to an unchanged approach. It states:

Different sets of factors and actors affect whether poor people achieve literacy and good health. Government policies and action are important, but private providers of education and health services, the interactions between the public sector and the market, social norms and practices, and individual and household behavior also play important roles. For example, health outcome depends on dietary choices at the household level and access to—and quality of – health services. (10)

The PRSP sourcebook, while theoretically promoting a multidimensional definition of poverty, continues to promote the adherence to market principles in the provision of education and health care, relying on user fees except for primary health care and basic health services. Hallmarks of SAPs are clear throughout the new initiatives, including the belief that the powers of the market will ensure accessible healthcare, the importance of privatization of services, and the power of the individual as a consumer to make choices regarding his or her health. This approach still presumes that the individual is not inhibited by structural violence and therefore capable of earning subsistence wages and acting in his or her best interest as a consumer.

Conclusion

Despite HIPC/MDRI focus on poverty alleviation and debt relief, the conditionally based initiatives perpetuate the tensions between the imperative of economic growth and the human right to health. Although increase in public expenditure seems to result from these initiatives, there is no guarantee that services are being made available to those who need them most. According to UNCTAD, “That the rich may benefit more than the poor from such services does not provide a rationale for introducing across-the-board user-fees but calls for more ingenious schemes which differentiate between the poor and the rich in their access to service” (59). Increased inequality under the new programs means that the structurally violent underpinning of the IFI approach has not been addressed.

The perpetuation of neoliberal ideologies persists in the new development initiatives due to the continued control of IFIs through their heavy involvement in the guidance of PRSPs and ability to veto proposals. The World Bank facilitates the consultative process of the PRSPs and the IMF assists in the creation of macro-economic policies (Cheru 523). Some creditors even threaten to freeze debt relief if the IMF expresses displeasure with country performance (Helleiner, 545). This power dynamic rings of the failed contingency-based SAPs. Abrahamsen reiterates:

Even commentators supportive of the general thrust of partnerships frequently draw attention to the difficulties in achieving ‘genuine’ partnership based on equality and mutual respect in a context where one party is in possession of the purse and the other the begging bowl, while more critical voices maintain that partnerships are simply a disguise for continued donor dominance of developing countries (1454).

While the perpetuation of neoliberal ideology does not invalidate HIPC/MDRI and the PRSP processes, they should not be regarded as a dramatic break from previous development agendas

as “conditionality and external debt remain the core guiding principles of the enhanced HIPC initiative” (Helleiner 541).

Overall, the IFIs fall short of their promise to redefine their development approach with the introduction of comprehensive debt relief and poverty eradication programs. Debt relief offered by HIPC/ MDRI is not enough to adequately strengthen public services or to create sustainable levels of debt in developing countries. IDA and IMF admit that although poverty reduction expenditure has risen by 2% GDP in post-decision-point HIPCs, it is unlikely that more than half of the countries will reach their MDGs (IDA 5). Dessy’s and Vencatachellum’s research confirms that social services will not be adequately strengthened, and they reject the hypothesis that “debt relief by itself translates into a higher share of public resources being allocated to either public education or health,” maintaining that “institutional reforms when interacted with debt relief are the only determinant of the share of resources allocated to public health” (202). Despite being shrouded in a new vocabulary, the HIPC/MDRI do not indicate a dramatic transformation of the IFI approach.

The specter of SAPs still haunts IFI development programs in the developing world. The neo-liberal framework of IMF and World Bank development approaches continues to threaten the economic sustainability of their programs. However, a new emphasis on country partnership, social services, and “robust” development aimed at eradicating poverty proves a marked improvement on past approaches and provides a unique window through which the benefits of debt-relief can be re-routed to mainstream HIV/AIDS. In this regard, HIPC and MDRI should be perceived as an opportunity rather than an accomplishment.

In order to be effective, HIPC and MCRI documents require a shift in priorities. The programs of the IFIs have facilitated the transmission of HIV/AIDS by deepening poverty,

increasing unemployment, worsening debt and eroding social services. These programs accept human health and equality as tradeoffs for economic growth. The human right to health can no longer be subject to cost benefit analysis. With the knowledge that increased spending on health and education will reduce HIV/AIDS incidence (Hoch 166), resources available for these purposes in the form of debt relief should be freed up without the requirement of timely and extensive government reform. In the conditions of poverty, debt, and illness that persist today, the waiting period between a HIPC decision point, completion point and MDRI approval point mean lost time and lost lives. The longer debt relief is withheld, the more dire the situation will become.

Governments and civil society groups can use the PRSP process to streamline HIV/AIDS and frame debt relief as a human rights issue. If AIDS can be officially recognized as a link in the cycle of poverty and debt that the IFIs already acknowledge, debt relief can become a necessary component in protecting the human right to health. Once HIV/AIDS is widely mainstreamed throughout the developing world as a cause and effect of poverty, the refusal of IFIs to employ a proven tool for reducing poverty and debt relief will represent a violation of the human right to health. This can be hastened by countries' incorporation of the right to health in their PRSPs.

The current global economic crisis poses a new threat to the countries of SSA and requires an immediate response. The countries that abided by SAPs and opened their economies up to international markets will likely be the hardest hit. The IMF and World Bank have already acknowledged that the global economic downturn is expected to once again increase debt burdens and have a strong negative effects on low-income countries through exports, FDI, remittances and (possibly) aid flows" (IDA 17). If the advice given to reform economies after

the last global economic crisis only serves to further debilitate the countries in the face of a new crisis, it is time for governments to demand their money back. In order to survive the current crisis and to break the cycle of poverty, debt, and illness before a new round of lending, debt, and transmission intensifies current problems, countries and civil society organizations must mainstream HIV/AIDS into their development instruments and demand rapid debt relief as necessary protection of the human right to health.

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